State of California—Health and Human Services Agency | Department of Developmental Services

VENDOR APPLICATION

DS 1890 (Rev. 12/2003) (Electronic Version)

Print

Applicant Name	Federal Tax ID or SSN *

Name of any Governing Body or Management Organization

Mailing Address	(Street)	(City)	(State)	(Zip)	(County)

Service Address *(If different than mailing address)*	(Street)	(City)	(State)	(Zip)	(County)

Applicant *(owner or executive director)*	Telephone number ( )

Type of Service to be Provided	Facility Capacity

Identification of the type of consultants, subcontractors and community resources to be used by the vendor as part of its service

CERTIFICATION

I hereby certify to the best of my knowledge and belief, this information is true, correct, and complies with Title 17, Section 54310(a).

Applicants Signature	Date
▶	

INSTRUCTIONS

Please read the Department of Developmental Services California Code of Regulations, available from the regional centers, prior to completing this form. Type or print his form. Mail to the regional center serving your area.

Attach applicable information outlined in Title 17, Section 54310(a)(10)

(A) Any license, credential, registration or permit required for the performance of the service or operation of the program, or proof of application for such document;

(B) Any academic degree required for performance or operation of the service;

(C) Any waiver from licensure, registration, certification, credential, or permit from the responsible controlling agency;

(D) The proposed or existing program design as required in Section 56712 and Section 56762, if applicable, for applicants seeking vendorization as community-based day programs;

(E) The proposed or existing staff qualifications and duty statements as required in sections 56722 and 56724 for applicants seeking vendorization as community-based day programs;

(F) The proposed or existing design as required in Section 56780 for applicants seeking vendorization as in-home respite services agencies;

(G) The proposed or existing staff qualifications and duty statements as required in Section 56792 for applicants seeking vendorization as in-home respite services agencies.

(H) The signed Medi-Cal Program Provider Agreement, Claim Certification, with the Department of Health Services, if required.

**** "Except for the Federal Tax ID or Social Security Number, all information provided by you on this form may be released to a member of the public pursuant to the Public Records Act, section 6250 et seq. of the California Government Code."***